

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2009)

☐ Draft
☐ Approved
☐ Amended

Student Information

Name: _____

Agency: _____

IEP Team Meeting Date: ____/____/____

STUDENT AND SCHOOL INFORMATION

First Name: _____ MI: ____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Grade: _____

Unique Student Identification Number (State): _____

Student Identification Number (local): _____

Date of Birth: • • (MM•DD•YYYY)

Age: _____ Gender: ☐ MALE ☐ FEMALE

EXISTING RACE CODES

- ☐ American Indian or Alaskan Native
☐ Asian or Pacific Islander
☐ Black or African American (not Hispanic)

- ☐ Hispanic or Latino
☐ White (not Hispanic)

NEW RACE CODES

- ☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American

- ☐ Native Hawaiian or other Pacific Islander
☐ White

Ethnicity: Hispanic or Latino ☐ Yes ☐ No

Student identified as Limited English Proficient: ☐ YES ☐ NO

Student's native language: _____

Residence County: _____

Residence School: _____

Service County: _____

Service School: _____

Which jurisdiction is financially responsible? _____

Is the student currently under the care and custody of a state agency? ☐ YES ☐ NO

If yes, name of state agency: _____

Does the student require a parent surrogate? ☐ YES ☐ NO

Parent Surrogate Name: _____ Surrogate Phone: _____

PARENT/GUARDIAN 1

First Name: _____ MI: ____ Last Name: _____

Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

Email: _____

Parent native language, if not English: _____

Interpreter needed? ☐ YES ☐ NO

PARENT/GUARDIAN 2

First Name: _____ MI: ____ Last Name: _____

Home Phone: (____) _____ - _____ Cell: (____) _____ - _____

Email: _____

Parent native language, if not English: _____

Interpreter needed? ☐ YES ☐ NO

Case Manager: _____

IEP Team Meeting Date(s): _____

IEP Annual Review Date: _____

☐ Parent was provided a copy of the *Procedural Safeguards Parental Rights* document.

Projected Annual Review Date: _____

Most Recent Evaluation Date: _____

Projected Evaluation Date: _____

Primary Disability: _____

Areas affected by disability: _____

EXIT INFORMATION

Exit date: • • (MM•DD•YYYY)

Exit category: ☐ A - Returned to general education ☐ B - Graduated with a Maryland High School Diploma ☐ C - Received Maryland High School Certificate of Program Completion
☐ D - Reached 21 years of age ☐ E - Deceased ☐ F - Moved, known to be continuing ☐ H - Dropped Out ☐ I - Special Case ☐ J - Parent revokes consent for services

IEP TEAM PARTICIPANTS

IEP Case Manager: _____

IEP Chair: _____

Parent/Guardian: _____

Parent/Guardian: _____

Principal/Designee: _____

General Educator: _____

Special Educator: _____

Guidance Counselor: _____

School Psychologist: _____

Social Worker: _____

Speech/Language Pathologist: _____

Student: _____

Agency Representative: _____

Others in attendance: _____

Others in attendance: _____

Others in attendance: _____

Name:

Agency:

IEP Team Meeting Date: / /

STUDENT PARTICIPATION ON DISTRICT/STATEWIDE ASSESSMENTS AND GRADUATION INFORMATION

PLAN FOR PARTICIPATION IN ASSESSMENTS TO BE ADMINISTERED DURING THE TERM OF THE CURRENT IEP

State graduation requirements can be found at www.marylandpublicschools.org.
Also record any additional local school system graduation requirements:

Graduation requirements explained to parents? ☐ YES ☐ NO
Student is pursuing a:
☐ Maryland High School Diploma ☐ Maryland High School Certificate of Program Completion

The student is officially identified as a ninth grade student effective in the academic school year (YYYY) - (YYYY).
The student was originally identified as participating in a
☐ 4 year ☐ 5 year ☐ 6 year plan.
The student is currently participating in a ☐ 4 year ☐ 5 year ☐ 6 year plan.

Will the student participate in the Maryland School Assessment aligned with grade level academic achievement standards in assessed grade? (MSA-Grades 3-8)
Reading ☐ YES ☐ NO Math ☐ YES ☐ NO Science ☐ YES ☐ NO

Will the student participate in the Modified Maryland School Assessment aligned with modified academic achievement standards in assessed grade? (Mod-MSA-Grades 3-8)
Reading ☐ YES ☐ NO Math ☐ YES ☐ NO Science ☐ YES ☐ NO

Will the student participate in the Maryland High School Assessment aligned with Core Learning Goals in assessed course? (HSA)
Algebra/Data Analysis ☐ YES ☐ NO English ☐ YES ☐ NO
Biology ☐ YES ☐ NO Government ☐ YES ☐ NO

Will the student participate in the Maryland High School Assessment aligned with Core Learning Goals/modified achievement standards in assessed course? (Mod-HSA)
Algebra/Data Analysis ☐ YES ☐ NO English ☐ YES ☐ NO
Biology ☐ YES ☐ NO Government ☐ YES ☐ NO

Will the student participate in Alternate Maryland School Assessment aligned with alternate academic/course achievement standards in reading, math and science in assessed grade? (Alt-MSA) ☐ YES ☐ NO

Document basis for decision(s):

Complete for high school seniors that may be eligible for an HSA waiver
IEP team has discussed the criteria of the waiver decision-making process for the student and supports an HSA waiver recommendation to the local superintendent.
☐ YES (If yes, specify date recommended) ☐ NO

PERFORMANCE SUMMARY

What was the student's performance on the Maryland Model for School Readiness (MMSR) Kindergarten Assessment?
 (MM•DD•YYYY)
☐ FULL ☐ APPROACHING ☐ DEVELOPING

Is the student limited English proficient? ☐ YES ☐ NO
What was the student's performance on the Language Assessment Scale (LAS) Links?
Assessment Date (MM•DD•YYYY) Score
☐ FULLY PROFICIENT ☐ LIMITED PROFICIENCY ☐ NOT PROFICIENT

What was the student's performance on MSA as of (MM•DD•YYYY)?
MSA Assessments Scale Score (Check Mod, if appropriate.)

Reading <input type="checkbox"/> Mod		<input type="radio"/> BASIC <input type="radio"/> PROFICIENT <input type="radio"/> ADVANCED
Math <input type="checkbox"/> Mod		<input type="radio"/> BASIC <input type="radio"/> PROFICIENT <input type="radio"/> ADVANCED
Science <input type="checkbox"/> Mod		<input type="radio"/> BASIC <input type="radio"/> PROFICIENT <input type="radio"/> ADVANCED

What was the student's performance, if applicable, on HSA as of (MM•DD•YYYY)?

HSA Assessments (Check Mod, if appropriate.)	Passing Score	Student's 1st Score	Student's 2nd Score	Student's Highest Score	Meets Standard	Bridge Plan Participant	Mod-HSA+ Participant
Algebra/ Data Analysis <input type="checkbox"/> Mod	412				<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
Biology <input type="checkbox"/> Mod	400				<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
English <input type="checkbox"/> Mod	396				<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
Government <input type="checkbox"/> Mod	394				<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
Combined Score	1602				<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

What was the student's performance, if applicable, on Alt-MSA as of (MM•DD•YYYY)?

Alt-MSA Assessments	% of Mastery Objectives	
Reading		<input type="radio"/> BASIC <input type="radio"/> PROFICIENT <input type="radio"/> ADVANCED
Math		<input type="radio"/> BASIC <input type="radio"/> PROFICIENT <input type="radio"/> ADVANCED
Science		<input type="radio"/> BASIC <input type="radio"/> PROFICIENT <input type="radio"/> ADVANCED

INDIVIDUALIZED EDUCATION PROGRAM (IEP) II. PRESENT LEVEL OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2009)

Name: _____

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IEP Team Meeting Date: ____/____/____

ACADEMIC _____

Document student's academic achievement and functional performance levels in academic areas, as appropriate.

Source(s): _____

Instructional Grade Level Performance: _____

(Consider private, state, local school system, and classroom based assessments, as applicable.)

Summary of Assessment Findings (including dates of administration): _____

Does this area impact the student's academic achievement and/or functional performance? ☐ YES ☐ NO

HEALTH _____

Source(s): _____

Level of Performance: _____

(Consider private, state, local school system, and classroom based assessments, as applicable.)

Summary of Assessment Findings (including dates of administration): _____

Does this area impact the student's academic achievement and/or functional performance? ☐ YES ☐ NO

PHYSICAL _____

Source(s): _____

Level of Performance: _____

(Consider private, state, local school system, and classroom based assessments, as applicable.)

Summary of Assessment Findings (including dates of administration): _____

Does this area impact the student's academic achievement and/or functional performance? ☐ YES ☐ NO

BEHAVIORAL _____

Source(s): _____

Level of Performance: _____

(Consider private, state, local school system, and classroom based assessments, as applicable.)

Summary of Assessment Findings (including dates of administration): _____

Does this area impact the student's academic achievement and/or functional performance? ☐ YES ☐ NO

Name:

Agency:

IEP Team Meeting Date: / /

PRESENT LEVEL OF ACADEMIC ACHIEVEMENT AND FUNCTIONAL PERFORMANCE
<p>What is the parental input regarding the student’s educational program?</p> <div></div>
<p>What are the student’s strengths, interest areas, significant personal attributes, and personal accomplishments? (Include preferences and interests for post-school outcomes, if appropriate.)</p> <div></div>
<p>How does the student’s disability affect his/her involvement in the general education curriculum?</p> <div></div>
<p>For preschool age children, how does the disability affect participation in appropriate activities?</p> <div></div>

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III. SPECIAL CONSIDERATIONS AND ACCOMMODATIONS

Name:

Agency:

IEP Team Meeting Date: / /

COMMUNICATION (required)

Does the student have special communication needs? ☐ YES ☐ NO

(If yes, describe the specific needs.) _____

ASSISTIVE TECHNOLOGY (AT) (required)

Consider AT device(s) and service(s) that are needed to increase, maintain or improve functional capabilities of a student with a disability.

The student needs an AT **device(s)** ☐ YES ☐ NO

If yes, AT **device(s)** will be addressed through:

- ☐ Supplementary Aids, Services, Program Modifications, and Supports
- ☐ Instructional and Testing Accommodations

The student needs an AT **service(s)** ☐ YES ☐ NO

If yes, AT **service(s)** will be addressed through:

- ☐ Supplementary Aids, Services, Program Modifications, and Supports
- ☐ Related Services
- ☐ Instructional and Testing Accommodations

Document basis for decision(s): _____

SERVICE FOR STUDENTS WHO ARE BLIND OR VISUALLY IMPAIRED

In the case of a student who is blind or visually impaired, provide for instruction in Braille and the use of Braille unless the IEP Team determines, after an evaluation of the student's reading and writing media that instruction in Braille is not appropriate for the student.

Instruction in Braille considered? ☐ YES ☐ NO

Evaluation date: • • (MM•DD•YYYY)

Is instruction in Braille appropriate? ☐ YES ☐ NO

Were parents provided information regarding Maryland School for the Blind? ☐ YES ☐ NO

Document basis for decision(s): _____

SERVICE FOR STUDENTS WHO ARE DEAF OR HEARING IMPAIRED

In the case of a student who is deaf or hearing impaired, consider language and communication needs, opportunities for direct communications, academic level, and full range of needs, including direct instruction in the student's language and communication mode.

Were parents provided information regarding Maryland School for the Deaf? ☐ YES ☐ NO

Document basis for decision(s): _____

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Name:

Agency:

IEP Team Meeting Date: / /

BEHAVIORAL INTERVENTION

In the case of a student whose behavior impedes the student's learning or that of others, consider the use of positive behavioral interventions and supports, and other strategies to address that behavior.

☐ Functional Behavioral Assessment (FBA) Assessment date: • •

Does the student require a Behavioral Intervention Plan (BIP)? ☐ YES ☐ NO

☐ Behavioral Intervention Plan Implementation date: • •

Document basis for decision(s): _____

SERVICE FOR STUDENTS WITH LIMITED ENGLISH PROFICIENCY

In the case of a student with limited English proficiency, consider the language needs of the student as such needs relate to the student's IEP.

Document basis for decision(s): _____

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III. SPECIAL CONSIDERATIONS AND ACCOMMODATIONS

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IEP Team Meeting Date: ____/____/____

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

1. PRESENTATION ACCOMMODATIONS: ('I' covers all instruction/intervention including Bridge Plan)

Visual Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-A: Large Print (Prior Code: III-A)	I, A
1-B: Magnification Devices (Prior Code: N/A, none)	I, A
1-C: Interpretation/Transliteration for the Deaf and Hard of Hearing (Prior Code: IV-D)	I, A
Tactile Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-D: Braille (Prior Code: III-B)	I, A
1-E: Tactile Graphics (Prior Code: N/A, none) NOTE: For purposes of State assessments, any tactile graphics needed are included with the Braille version of the test.	I, A
Auditory Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-F: Human Reader, Audio Tape, or Compact Disk Recording for Verbatim Reading of Entire Test (Prior Codes: IV-F, IV-H)	I, A*
1-G: Human Reader, Audio Tape, or Compact Disk Recording for Verbatim Reading of Selected Sections of Test (Prior Codes: IV-G, IV-I)	I, A*
1-H: Audio Amplification Devices (Prior Code: IV-D)	I, A
1-J: Books on Tape (Prior Code: III-C)	I, N/A
1-K: Recorded Books (Prior Code: III-C)	I, N/A
Multi-Sensory Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-L: Video Tape and Descriptive Video (Prior Code: N/A, none) NOTE: No Maryland assessments currently incorporate video-taped stimulus materials. However, if video tape is used, students must have access to closed captioning on video materials, as appropriate.	I, N/A
1-M: Screen Reader for Verbatim Reading of Entire Test (Prior Codes: IV-F, IV-H)	I, A*
1-N: Screen Reader for Verbatim Reading of Selected Sections of Test (Prior Codes: IV-G, IV-I)	I, A*
1-O: Visual Cues (Prior Code: N/A)	I, A
1-P: Notes, Outlines, and Instructions (Prior Code: N/A, none)	I, N/A
1-Q: Talking Materials (Prior Code: III-C)	I, A
Other Presentation Accommodations	Conditions for Use In Instruction and Assessment
1-R: Other (Prior Code: IV-J)	Determined on a case-by-case basis in consultation with MSDE

* Use of the verbatim reading accommodation is permitted on all assessments as a standard accommodation, with the exception of:

(1) the Maryland School Assessment (MSA) in reading, grade 3 only, which assess a student's ability to decode printed language. Students in grade 3 receiving this accommodation on the assessment will receive a score based on standards 2 and 3 (comprehension of informational and literary reading material) but will not receive a score for standard 1, general reading processes.

(2) The Maryland Functional Reading Test.

Any screen reader may be used for instruction, but the only screen reader currently supported by the State for assessment is the Kurzweil™ 3000. In order for students to use the Kurzweil™ 3000 screen reader for testing, students must have used a screen reader in instruction and have had an opportunity to become familiar with the operation of the Kurzweil™ 3000 interface. Although a Human reader is always permissible to deliver a verbatim reading accommodation, the State encourages the use of screen readers on State testing, to promote standardization of the verbatim reading accommodation.

Discussion to support decision: _____

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Name:

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IEP Team Meeting Date: / /

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

2. RESPONSE ACCOMMODATIONS: ('I' covers all instruction/intervention including Bridge Plan)

Response Accommodations	Conditions for Use In Instruction and Assessment
2-A: Scribe (Prior Codes: V-B, V-E)	I, A
2-B: Speech-to-Text (Prior Codes: III-D, III-E)	I, A
2-C: Large-Print Response Book (Prior Code: III-A)	I, A
2-D: Braille (Prior Code: III-B)	I, A
2-E: Electronic Note-Takers and Word Processors (Prior Code: N/A, none)	I, A
2-F: Tape Recorder (Prior Code: V-C)	I, A
2-G: Respond on Test Booklet (Prior Code: V-A)	I, A
2-H: Monitor Test Response (Prior Code: V-D)	I, A
Materials or Devices Used to Solve or Organize Responses	Conditions for Use In Instruction and Assessment
2-J: Calculation Devices (Prior Code: III-C)	I, A
2-K: Spelling and Grammar Devices (Prior Code: III-D)	I, A*
2-L: Visual Organizers (Prior Code: N/A, none)	I, A**
2-M: Graphic Organizers (Prior Code: N/A, none)	I, A
2-N: Bilingual Dictionaries (Prior Code: III-F)	I, A
Other Response Accommodations	Conditions for Use In Instruction and Assessment
2-O: Other (Prior Code: V-J)	Determined on a case-by-case basis in consultation with MSDE

* Spelling and grammar devices are not permitted to be used on the English High School Assessment.

** Photocopying of secure test materials requires approval and must be done under the supervision of the Local Accountability Coordinator (LAC). Photocopied materials must be securely destroyed under the supervision of the LAC. Use of highlighters may be limited on certain machine-scored test forms, as highlighting may obscure test responses. Check with the LAC before allowing the use of highlighters on any State assessment.

Discussion to support decision: _____

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Name: _____

Agency: _____

IEP Team Meeting Date: ____/____/____

INSTRUCTIONAL AND TESTING ACCOMMODATIONS

3. TIMING AND SCHEDULING ACCOMMODATIONS: ('I' covers all instruction/intervention including Bridge Plan)

Timing and Scheduling Accommodations	Conditions for Use In Instruction and Assessment
3-A: Extended Time (Prior Code: I-C)	I, A
3-B: Multiple or Frequent Breaks (Prior Code: I-A)	I, A
3-C: Change Schedule or Order of Activities – Extend Over Multiple Days (Prior Code: I-B)	I, A
3-D: Change Schedule or Order of Activities – Within One Day (Prior Code: I-D)	I, A
Other Timing and Scheduling Accommodations	Conditions for Use In Instruction and Assessment
3-E: Other (Prior Code: I-E)	Determined on a case-by-case basis in consultation with MSDE

Discussion to support decision: _____

4. SETTING ACCOMMODATIONS: ('I' covers all instruction/intervention including Bridge Plan)

Setting Accommodations	Conditions for Use In Instruction and Assessment
4-A: Reduce Distractions to the Student (Prior Codes: II-A, II-B, II-E, II-F)	I, A
4-B: Reduce Distractions to Other Students (Prior Code: II-G)	I, A
4-C: Change Location to Increase Physical Access or to Use Special Equipment – Within School Building (Prior Codes: II-C, II-D)	I, A
4-D: Change Location to Increase Physical Access or to Use Special Equipment – Outside School Building (Prior Code: II-I)	I, A
Other Setting Accommodations	Conditions for Use In Instruction and Assessment
4-E: Other (Prior Code: I-E)	Determined on a case-by-case basis in consultation with MSDE

Discussion to support decision: _____

☐ Instructional and testing accommodations were considered and no instructional and testing accommodations are required at this time.

Discussion to support decision: _____

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IEP Team Meeting Date: ____/____/____

SUPPLEMENTARY AIDS, SERVICES, PROGRAM MODIFICATIONS AND SUPPORTS

Service Nature (Indirect)	Service Description	Begin Date	End Date	Provider(s) Ⓟ = Primary, ○ = Other
<input type="radio"/> Classroom Instruction <input type="radio"/> Physical Education <input type="radio"/> Speech/Language Therapy <input type="radio"/> Travel Training <input type="radio"/> Audiological Services <input type="radio"/> Psychological Services <input type="radio"/> Occupational Therapy <input type="radio"/> Physical Therapy <input type="radio"/> Recreation <input type="radio"/> Early Identification & Assessment <input type="radio"/> Counseling Services <input type="radio"/> Medical Services (Diagnostic and Evaluation) <input type="radio"/> School Health Services <input type="radio"/> Social Work Services <input type="radio"/> Parent Counseling and Training <input type="radio"/> Other Therapies _____	<input type="radio"/> Rehabilitative Counseling <input type="radio"/> Orientation and Mobility Training Service <input type="radio"/> Interpreting Services <input type="radio"/> Speech/Language Therapy as a Related Service <input type="radio"/> Assistive Technology Services <input type="radio"/> Career and Technology Education Program w/Support Services <input type="radio"/> Vocational Evaluation <input type="radio"/> Special Education Program w/Pre-Vocation Objectives <input type="radio"/> Other Aid, Program Modification or Support _____	Anticipated Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Periodically <input type="radio"/> Quarterly <input type="radio"/> Semi-annually <input type="radio"/> Other _____	MM•DD•YYYY MM•DD•YYYY Duration _____ weeks	<div> <input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____ </div> <div> <input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant </div>

Clarify the location and manner in which Supplementary Aids, Services, Program Modifications and Supports to or, on behalf of, the student will be provided: _____

Discussion to support decisions: _____

☐ Supplementary Aids, Services, Program Modifications and Supports were considered and none are required at this time.

Discussion to support decision(s): _____

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IEP Team Meeting Date: ____ / ____ / ____

EXTENDED SCHOOL YEAR (ESY)

The IEP Team should determine if any of the factors below will significantly jeopardize the student's ability to receive some benefit from the student's educational program during the regular school year, if the student does not receive ESY services. ESY services are the individualized extension of specific special education and related services that are provided beyond the normal school year of the public agency, in accordance with the IEP, at no cost to the parents.

☐ ESY Decision Deferred

When considering ESY, answer YES or NO and document the decision:

1. Does the student's IEP include annual goals related to critical life skills? ☐ YES ☐ NO

Discussion to support decision: _____

1a. Is there a likely chance of substantial regression of critical life skills caused by the normal school break and a failure to recover those lost skills in a reasonable time? ☐ YES ☐ NO

Discussion to support decision: _____

1b. Is the student demonstrating a degree of progress toward mastery of IEP goals related to critical life skills? ☐ YES ☐ NO

Discussion to support decision: _____

2. Is there a presence of emerging skills or breakthrough opportunities? ☐ YES ☐ NO

Discussion to support decision: _____

3. Are there significant interfering behaviors? ☐ YES ☐ NO

Discussion to support decision: _____

4. Does the nature and severity of the disability warrant ESY? ☐ YES ☐ NO

Discussion to support decision: _____

5. Are there other special circumstances that require ESY? ☐ YES ☐ NO

Discussion to support decision: _____

After considering all of the above questions, will the benefits that the student receives from his/her educational program during the regular school year be significantly jeopardized if the student is not provided ESY? ☐ YES, student is eligible for ESY service.

☐ NO, student is not eligible for ESY service.

Document basis for decision(s): _____

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TRANSITION (To be completed annually, beginning at age 14 or younger, if determined appropriate.)

STUDENT PREFERENCES AND INTERESTS:

The postsecondary goal(s) are to be based on the student's interests, preferences and age appropriate transition assessments.

Date of Student Interview: • • (MM•DD•YYYY)

Discussion of student's interests, preferences and age appropriate transition assessments: _____

POSTSECONDARY GOALS (Outcomes):

Postsecondary goal(s) are to be recorded here. At least one goal must be indicated for training and/or education.

Employment (required): _____

Training: _____

Education: _____

Independent Living (if appropriate): _____

COURSE OF STUDY:

The course of study is to support the stated postsecondary goal(s)

- | | | |
|-----------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="radio"/> Arts, Media & Communication | <input type="radio"/> Business Management & Finance | <input type="radio"/> Construction & Development |
| <input type="radio"/> Education, Training & Child Services | <input type="radio"/> Health, Bioscience, & Medicine | <input type="radio"/> Information Technology |
| <input type="radio"/> Engineering, Scientific Research & Manufacturing Technology | <input type="radio"/> Environmental, Agricultural & Natural Resource Systems | <input type="radio"/> Transportation, Distribution & Logistics |
| <input type="radio"/> Law, Government, Public Safety & Administration | <input type="radio"/> Human, Consumer Services, Hospitality & Tourism | |

Student is enrolled in the following Functional and Skill Development Activities:

- ☐ Job Sampling & Employment training ☐ Supported Employment ☐ Activities of Daily Living

PROJECTED CATEGORY OF EXIT:

- The student will exit with: ☐ Maryland High School Diploma
- ☐ with 2 credits of Foreign Language
 - ☐ with 2 credits of Advanced Technology
 - ☐ with 4 credits of Career and Technology Program
- ☐ Certificate of Program Completion at the end of the school year the student turns 21
- ☐ Certificate of Program Completion prior to the end of the school year the student turns 21 (Parent and student choice)

PROJECTED DATE OF EXIT:

The student is participating in a _____ year program and is projected to exit/graduate school _____ (month, day, year)

Have the student and parents been informed that rights under IDEA do not transfer to students with disabilities on reaching age of majority, except under limited circumstances, as described in Education Article §8-412.1, Annotated Code of Maryland? ☐ Yes ☐ N/A

Document basis for decision(s): _____

AGENCY LINKAGE:

The student has been referred to the appropriate agency for transition and/or postsecondary services:

- ☐ DORS (Department of Rehabilitative Services)
- ☐ DDA (Developmental Disabilities Agency)
- ☐ MHA (Mental Hygiene Administration)

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

III. SPECIAL CONSIDERATIONS AND ACCOMMODATIONS

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2009)

Name: _____

Agency: _____

IEP Team Meeting Date: / /

TRANSITION ACTIVITIES

TRANSITION SERVICES/ACTIVITIES:

Transition services are a coordinated set of activities for a student with a disability that is designed within a results oriented process that will facilitate the student's movement from school to postsecondary activities.

Academic: _____

Responsible Party: _____

Employment Training: _____

Responsible Party: _____

Activities of Daily Living: _____

Responsible Party: _____

Independent Living: _____

Responsible Party: _____

Transportation: _____

Responsible Party: _____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

III. SPECIAL CONSIDERATIONS AND ACCOMMODATIONS

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2009)

Name:

Agency:

IEP Team Meeting Date: / /

ANTICIPATED SERVICES FOR TRANSITION

Services you anticipate a student 14 years and older will need within one year of exiting the agency.
The adult services recommended on this page are those anticipated and not entitlement services.

General Services

- ☐ No Services Needed: upon exiting from the educational system.
- ☐ Public income maintenance: Social Security Income (SSI), Social Security Disability Income (SSDI), welfare, Medicaid, public health insurance, etc.
- ☐ Transportation: specialized transportation including paratransit.

Developmental Disabilities Administration (DDA)

- ☐ Day Habilitation
- ☐ Community Residential Services
- ☐ Supported Employment
- ☐ Family and Individual Support Services
- ☐ Behavior/Support Services
- ☐ Community Supported Living Arrangements (CSLA)

Further Education/Training

- ☐ Continuing and Adult Education: including Adult Basic Ed (ABE), General Education Development (GED), adult high school diploma, and adult compensatory or special education.
- ☐ Higher Education Support Services: note takers, educational technology, modified testing time, mentoring and guidance, study skills, and self advocacy training.
- ☐ Career School Support Services: support services in programs such as career schools, Job Training Partnership Act programs (JTPA), and Job Corps.

Mental Hygiene Administration (MHA)

- ☐ Mental Health Evaluation and Treatment
- ☐ Psychiatric Rehabilitation Programs
- ☐ Residential Rehabilitation Programs
- ☐ Supported Employment
- ☐ Respite Care

Division of Rehabilitation Services (DORS)

- ☐ Assessment and Evaluation
- ☐ Vocational Rehabilitation Counseling and Guidance
- ☐ Job Search, Placement Assistance, and Follow Up Services
- ☐ Medical Rehabilitation
- ☐ Vocational and Other Training Services
- ☐ Rehabilitation Technology Services
- ☐ Support Services

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2009)

IV. GOALS

Name: _____ Agency: _____ IEP Team Meeting Date: ____/____/____

GOAL _____	
Goal: _____ _____ _____	
By: <input type="text"/> <input type="text"/> • <input type="text"/> <input type="text"/> • <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (MM•DD•YYYY)	
Evaluation Method: <input type="checkbox"/> INFORMAL PROCEDURES <input type="checkbox"/> CLASSROOM-BASED ASSESSMENT <input type="checkbox"/> OBSERVATION RECORD <input type="checkbox"/> STANDARDIZED ASSESSMENT <input type="checkbox"/> PORTFOLIO ASSESSMENT <input type="checkbox"/> OTHER _____	
With _____ <input type="checkbox"/> % Accuracy <input type="checkbox"/> % decrease <input type="checkbox"/> ____ out of ____ trials <input type="checkbox"/> % increase <input type="checkbox"/> other _____	
ESY goal? <input type="radio"/> YES <input type="radio"/> NO	
Objective 1: _____ _____ _____ _____ Objective 2: _____ _____ _____ _____	Objective 3: _____ _____ _____ _____ Objective 4: _____ _____ _____ _____
Progress Toward Goal	
Progress Report 1 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) <input type="radio"/> Not yet introduced Description: _____
Progress Report 2 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) <input type="radio"/> Not yet introduced Description: _____
Progress Report 3 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) <input type="radio"/> Not yet introduced Description: _____
Progress Report 4 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) <input type="radio"/> Not yet introduced Description: _____
Progress Report 5 Date _____	Progress Code: <input type="radio"/> Achieved <input type="radio"/> Making sufficient progress to meet goal <input type="radio"/> Not making sufficient progress to meet the goal (IEP team needs to meet to address insufficient progress) <input type="radio"/> Not yet introduced Description: _____
How will the parent be notified of the student's progress toward the IEP goals? _____	
How often? <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> INTERIM <input type="checkbox"/> QUARTERLY <input type="checkbox"/> END OF MARKING PERIOD <input type="checkbox"/> OTHER _____	

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

V. SERVICES

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2009)

Name: _____

Agency: _____

IEP Team Meeting Date: ____ / ____ / ____

SERVICES

☐ SPECIAL EDUCATION SERVICES

Service Nature	Location	Service Description			Begin Date	End Date	Provider(s) P = Primary, O = Other		Summary of Service
<input type="radio"/> Classroom Instruction (Identifying the number of sessions for Classroom Instruction is optional) <input type="radio"/> Physical Education <input type="radio"/> Speech/Language Therapy <input type="radio"/> Travel Training	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____	<input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> yearly _____ Hrs. _____ Min.
ESY Service Nature	ESY Location	ESY Service Description			ESY Begin Date	ESY End Date	ESY Provider(s) P = Primary, O = Other		Summary of Service
<input type="radio"/> Classroom Instruction (Identifying the number of sessions for Classroom Instruction is optional) <input type="radio"/> Physical Education <input type="radio"/> Speech/Language Therapy <input type="radio"/> Travel Training	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____	<input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> yearly _____ Hrs. _____ Min.

Discussion of service(s) delivery: _____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2009)

V. SERVICES

Name: _____

Agency: _____

IEP Team Meeting Date: ____ / ____ / ____

SERVICES

☐ RELATED SERVICES

Service Nature	Location	Service Description			Begin Date	End Date	Provider(s) ☑ = Primary, ○ = Other		Summary of Service
<input type="radio"/> Audiological Services <input type="radio"/> Psychological Services <input type="radio"/> Occupational Therapy <input type="radio"/> Physical Therapy <input type="radio"/> Recreation <input type="radio"/> Early Identification & Assessment <input type="radio"/> Counseling Services <input type="radio"/> School Health Services <input type="radio"/> Social Work Services <input type="radio"/> Parent Counseling & Training <input type="radio"/> Rehabilitative Counseling <input type="radio"/> Orientation & Mobility Training Services <input type="radio"/> Assistive Technology Services <input type="radio"/> Medical Services (Diagnostic & Evaluation) <input type="radio"/> Other Therapies _____ <input type="radio"/> Interpreting Services <input type="radio"/> Speech/Language Therapy	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<div> <input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____ </div> <div> <input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant </div>	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> yearly ____ Hrs. ____ Min.	
ESY Service Nature	ESY Location	ESY Service Description			ESY Begin Date	ESY End Date	ESY Provider(s) ☑ = Primary, ○ = Other		Summary of Service
<input type="radio"/> Audiological Services <input type="radio"/> Psychological Services <input type="radio"/> Occupational Therapy <input type="radio"/> Physical Therapy <input type="radio"/> Recreation <input type="radio"/> Early Identification & Assessment <input type="radio"/> Counseling Services <input type="radio"/> School Health Services <input type="radio"/> Social Work Services <input type="radio"/> Parent Counseling & Training <input type="radio"/> Rehabilitative Counseling <input type="radio"/> Orientation & Mobility Training Services <input type="radio"/> Assistive Technology Services <input type="radio"/> Medical Services (Diagnostic & Evaluation) <input type="radio"/> Other Therapies _____ <input type="radio"/> Interpreting Services <input type="radio"/> Speech/Language Therapy	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually Duration _____ weeks	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<div> <input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____ </div> <div> <input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant </div>	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> yearly ____ Hrs. ____ Min.	

Discussion of service(s) delivery: _____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

V. SERVICES

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2009)

Name:

Agency:

IEP Team Meeting Date: / /

SERVICES

☐ CAREER AND TECHNOLOGY EDUCATION SERVICES

Service Nature	Location	Service Description			Begin Date	End Date	Provider(s) P <input type="radio"/> = Primary, <input type="radio"/> = Other	Summary of Service
<input type="radio"/> Career and Technology Education Program w/Support Services <input type="radio"/> Vocational Evaluation <input type="radio"/> Special Education Program with Pre-Vocation Objectives	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<div> <input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____ </div> <div> <input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant </div>	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> yearly _____ Hrs. _____ Min.
ESY Service Nature	ESY Location	ESY Service Description			ESY Begin Date	ESY End Date	ESY Provider(s) P <input type="radio"/> = Primary, <input type="radio"/> = Other	Summary of Service
<input type="radio"/> Career and Technology Education Program w/Support Services <input type="radio"/> Vocational Evaluation <input type="radio"/> Special Education Program with Pre-Vocation Objectives	<input type="radio"/> In General Education <input type="radio"/> Outside General Education	Number of Sessions <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Other _____	Length of Time (Select the length of time, in 15 minute increments, that the service is provided during each session) <input type="radio"/> 15 Min. <input type="radio"/> 30 Min. <input type="radio"/> 45 Min. <input type="radio"/> 1 Hr. <input type="radio"/> 1 Hr. 15 Min. <input type="radio"/> 1 Hr. 30 Min. <input type="radio"/> 2 Hrs. <input type="radio"/> 3 Hrs. <input type="radio"/> Other _____	Frequency <input type="radio"/> Daily <input type="radio"/> Weekly <input type="radio"/> Monthly <input type="radio"/> Yearly <input type="radio"/> Only once <input type="radio"/> Quarterly <input type="radio"/> Semi-annually	MM•DD YYYY	MM•DD YYYY Duration _____ weeks	<div> <input type="radio"/> Orientation & Mobility Specialist <input type="radio"/> Speech/Language Pathologist <input type="radio"/> Teacher of the Hearing Impaired <input type="radio"/> Teacher of the Visually Impaired <input type="radio"/> Occupational Therapist <input type="radio"/> Pupil Personnel Worker <input type="radio"/> Physical Education Tchr <input type="radio"/> Rehabilitation Services Staff <input type="radio"/> General Education Tchr <input type="radio"/> Career & Technology Tchr <input type="radio"/> Department of Social Services (DSS) <input type="radio"/> Mental Hygiene Administration (MHA) <input type="radio"/> Developmental Disabilities Administration (DDA) <input type="radio"/> Division of Rehabilitation Services (DORS) <input type="radio"/> Other Agency _____ <input type="radio"/> Special Education Classroom Teacher <input type="radio"/> Other Service Provider _____ </div> <div> <input type="radio"/> Audiologist <input type="radio"/> Psychologist <input type="radio"/> IEP Team <input type="radio"/> Interpreter <input type="radio"/> Instructional Assistant <input type="radio"/> Physical Therapist <input type="radio"/> Home-Based Teacher <input type="radio"/> Guidance Counselor <input type="radio"/> School Social Worker <input type="radio"/> Recreational Therapist <input type="radio"/> Certified Occupational Therapy Assistant <input type="radio"/> Physical Therapy Assistant <input type="radio"/> Speech/Language Assistant </div>	Total service time: <input type="radio"/> weekly <input type="radio"/> monthly <input type="radio"/> yearly _____ Hrs. _____ Min.

Discussion of service(s) delivery: _____

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2009)

VI. PLACEMENT DATA

Name: _____

Agency: _____

IEP Team Meeting Date: ____ / ____ / ____

LEAST RESTRICTIVE ENVIRONMENT (LRE) DECISION MAKING & PLACEMENT SUMMARY

A student with a disability is not removed from general education in an age-appropriate instructional setting solely because of needed modifications to the general curriculum.

What placement option(s) did the IEP team consider? _____

If removed from the general education environment, explain reasons why services cannot be provided in the general education environment with the use of supplementary aids and services: _____

Document basis for decision(s): _____

{ Total time in school week: ____ hrs. ____ minutes/week } - { Total time outside of General Education: ____ hrs. ____ minutes/week } = { Total time in General Education: ____ hrs. ____ minutes/week }

- ☐ Special education placement (ages 3-5): Average ____ %/day
- | | | |
|-----------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> IN REGULAR EARLY CHILDHOOD SETTING (at least 80%) | <input type="checkbox"/> PUBLIC SEPARATE DAY SCHOOL | <input type="checkbox"/> HOME |
| <input type="checkbox"/> IN REGULAR EARLY CHILDHOOD SETTING (40% - 79%) | <input type="checkbox"/> PRIVATE SEPARATE DAY SCHOOL | <input type="checkbox"/> SERVICE PROVIDER LOCATION |
| <input type="checkbox"/> IN REGULAR EARLY CHILDHOOD SETTING (less than 40%) | <input type="checkbox"/> PUBLIC RESIDENTIAL FACILITY | |
| <input type="checkbox"/> SEPARATE CLASS | <input type="checkbox"/> PRIVATE RESIDENTIAL FACILITY | |
- ☐ Special education placement (ages 6-21): Average ____ %/day
- | | | | |
|-------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> INSIDE GENERAL EDUCATION (80% or more) | <input type="checkbox"/> PUBLIC SEPARATE DAY SCHOOL | <input type="checkbox"/> PRIVATE RESIDENTIAL FACILITY | <input type="checkbox"/> PARENTALLY PLACED IN PRIVATE SCHOOL |
| <input type="checkbox"/> INSIDE GENERAL EDUCATION (40% - 79%) | <input type="checkbox"/> PRIVATE SEPARATE DAY SCHOOL | <input type="checkbox"/> HOMEBOUND/HOSPITAL | |
| <input type="checkbox"/> INSIDE GENERAL EDUCATION (less than 40%) | <input type="checkbox"/> PUBLIC RESIDENTIAL FACILITY | <input type="checkbox"/> CORRECTIONAL FACILITIES | |

In selecting the LRE, are there any potential harmful effects on the student or quality of services he or she needs? ☐ YES ☐ NO

If yes, document basis for decision(s): _____

Are the services *in* the student's home school (the school the student would attend if not disabled)? ☐ YES ☐ NO If no, document basis for decision(s): _____

If no, is placement as *close as possible to* the student's home? ☐ YES ☐ NO If no, document basis for decision(s): _____

Is special transportation needed? ☐ YES ☐ NO If Yes, list all specialized equipment, if needed: _____

Are personnel needed to assist the student during transportation? ☐ YES ☐ NO If yes, explain: _____

Document basis for decision(s) (including consideration of the amount of time and distance involved in travel): _____

Provide an explanation to the extent, if any, the student will not participate with non-disabled peers in academic, non-academic, and extracurricular activities? _____

SSIS Residence County _____ SSIS Residence School _____

SSIS Service County _____ SSIS Service School _____

CHILD COUNT ELIGIBILITY CODES

- ☐ (1) Eligible student with a disability served in a public school or placed in a nonpublic school by the public agency to receive FAPE.
- ☐ (2) Eligible parentally placed private school student with a disability receiving special education and/or related service through a service plan from the public agency.
- ☐ (3) Eligible parentally placed private school student with a disability NOT receiving service from the public agency.
- ☐ (4) Eligible public school student with a disability not receiving services due to parent refusal of initial services.

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

MARYLAND STATE DEPARTMENT OF EDUCATION (MSDE) DIVISION OF SPECIAL EDUCATION/EARLY INTERVENTION SERVICES (Form approved by MSDE for use July 1, 2009)

VII. AUTHORIZATION(S)

Name:

Agency:

IEP Team Meeting Date: / /

AUTHORIZATION(S)

CONSENT FOR INITIATION OF SERVICES (initial IEP only)

I have received a copy of the Evaluation Report informing me in writing of the reasons for this action.

The special education and related services will be provided as described in the IEP. I understand that the IEP will be reviewed periodically but not less than annually.

I understand that records will not be released without my signed and written consent except under the provisions of the Family Education Rights and Privacy Act (FERPA). This law allows the release of educational records to a public school or educational agency.

I understand that my consent is voluntary and that I may revoke consent at any time. Should I revoke consent it is not retroactive. If I revoke consent, in writing, for my child to receive special education services after my child is initially provided special education and related services, the public agency is not required to amend my child's education records to remove any references to my child's receipt of special education and related services because of my revocation and consent.

I understand that the public agency will submit information that will be used for the special services information system. This system will be used by the MSDE and other State Agencies, as appropriate, to enable funding of programs and to assure my child's rights to any needed assessment.

I have been informed of the determination(s) of the IEP team in my native language or other mode of communication.

I have been informed of my rights, as explained in the *Procedural Safeguards - Parental Rights* document, I have received.

I consent to the initiation of special education and related services for my child, as specified in my child's IEP.

Parent Signature:

Date:

MEDICAL ASSISTANCE (MA)

Is the student eligible for MA? ☐ Yes ☐ No MA Number _____

I agree to Service Coordination for Children with Disabilities and that the Service Coordinator(s) identified on this IEP may be appointed as MA Service Coordinator(s). (COMAR 10.09.52)

I understand that I am free to choose an MA Service Coordinator for my child. At this time, I accept the following Service Coordinator(s).

MA Service Coordinator Name: _____

MA Service Coordinator Name: _____

I understand that if I wish to change the MA Service Coordinator in the future, I can call the school to make a change.

I understand that the purpose of this service is to assist in gaining access to needed medical, social, educational, and other services.

I give permission to the provider agency to recover costs from Medicaid for service coordination, as well as health-related services, related to the implementation of my child's IEP goals.

I understand that if I refuse to allow the provider agency access to MA funds, it does not relieve the provider agency of its responsibility to ensure that all required services are provided to my child at no cost to parent.

I understand that this service does not restrict or otherwise affect my child's eligibility for other MA benefits. I also understand that my child may not receive a similar type of case management service under MA if he/she qualifies for more than one type.

I understand that the public agency will submit information that will be used for the special services information system. This system will be used by the MSDE and other State Agencies, as appropriate, to enable funding of programs and to assure my child's rights to any needed assessment.

Parent Signature:

Date: